REDETERMINATION: STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR THE APPROVED RELATIVE CAREGIVER (ARC) FUNDING OPTION PROGRAM

INSTRUCTIONS: Please complete in ink all of the questions to the left of the heavy black line. If you need more space, attach another sheet of paper. Fill out this form for each participating child/youth. (This form, the ARC 2, is for redetermination. To apply for the ARC Program, complete the ARC 1 form.)

COUNTY USE ONLY

COUNTY AND AGENCY

DATE RECEIVED

CASE NAME

CASE NUMBER

WORKER NAME AND NUMBER

1. Approved Relative Caregiver's Name | **Phone** ( )

Birthdate (Month, Day, Year) | Social Security Number

2. Child/Youth's Name (First, Middle, Last) | Gender ☐ Male ☐ Female

Address

Birthdate (Month, Day, Year) | Birthplace (City, State, Country)

Social Security Number

Relationship to Approved Relative Caregiver

3. Does the child/youth still live with you? ☐ YES ☐ NO

4. Does the child/youth have, or expect to have, any new property?

☐ YES ☐ NO

If "**YES**," list below:

PROPERTY TYPE	VALUE

5. Did the child's/youth's income change or is it expected to change?

☐ YES ☐ NO

If "**YES**," please list below:

TYPE	AMOUNT	WHEN

Will this income continue? ☐ YES ☐ NO

Please explain:

☐ Verification of property: _____

☐ Verification of income: _____

☐ Verification provided

☐ Exempt

CERTIFICATION

I understand that:

- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under state and federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting ARC benefits.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.

I declare under penalty of perjury under the laws of the State of California that the information contained on this Statement of Facts is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPROVED RELATIVE CAREGIVER | **DATE**

COUNTY USE ONLY

☐ INELIGIBLE AT REDETERMINATION (Reason)

☐ ELIGIBLE AT REDETERMINATION

☐ CalWORKs Eligible ☐ ARC-only Eligible

(Explain any eligibility changes, such as no longer CalWORKs eligible but still ARC eligible.)

Eligibility Redetermination Date:

Signature of County Worker | Date

Signature of Supervisor | Date